

# Clinic Registration Form

## City Residents

To qualify for the City Resident rate, **the camper must reside within the corporate City limits of Gaithersburg\*.**

City residents are those individuals residing within the City's corporate tax limits. Do not assume that a Gaithersburg mailing address is within the City's corporate tax limits.

## \*Falsifying Registration Information

Falsifying registration information by either claiming City residency or falsifying the age of the camper will result in the denial of the registration.

**Age Requirement:** Participation in the clinics is based on the age of the participant on the first day of the program.

**Payment Policy: Full Payment** is required when registering for all programs with the exception of School of Basketball.

**Refund Policy:** Refund requests must be made in writing at least two weeks prior to the start of each program session.

**Financial Assistance:** Financial aid is not available for summer clinics.

**Many clinics quickly fill to capacity. In other cases, clinics are cancelled before the starting date if they appear to be under-enrolled. Please register during the registration period to allow for efficient organization of the clinics.**

## CLINIC REGISTRATION FORM

☐ Check here if new address/phone since last time registered.

Payer's Last Name \_\_\_\_\_ Payer's First Name \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ City Resident ☐ Nonresident ☐

Participant's Name	Sex M/F	Birthdate M/D/Y	Activity Name	Activity #	Location	Start Date	Grade Fall '06	School Fall '06	Fee
Example: Dylan Smith	M	7/03/98	Basketball Clinic	18744	Activity Center	6/19	5	SHES	\$75.00
TOTAL \$									

I hereby grant permission for me/my child to attend the activity sponsored by the City of Gaithersburg. I understand that I am responsible for my/my child's insurance in case of injury. Furthermore, I understand that although safety precautions will be observed, the City of Gaithersburg, employees and agents will not be responsible for any personal property lost by me/my child or for any injury sustained in the program. I also consent to the City's use of any photographs and/or video tapes made of the program.

Print Parent/Guardian Name \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Does your child have any allergies, medications or conditions that may affect participation in the program? Y ☐ N ☐

Please specify: \_\_\_\_\_

Amount Paid \$ \_\_\_\_\_ Cash ☐ Check # \_\_\_\_\_  
 Visa/MC/Discover# \_\_\_\_\_ Exp.Date \_\_\_\_/\_\_\_\_  
 Signature (name on card) \_\_\_\_\_  
 Print Name \_\_\_\_\_

## OFFICE USE ONLY:

Rec'd: \_\_\_\_\_ Initials \_\_\_\_\_  
 W P M F Resident: Y N  
 Pr: \_\_\_\_\_